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CLINICAL LECTURES.

CLOSURE OF VULVA FOR VESICO-VAGINAL FISTULA.—FIBROID TUMORS.

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Closure of Vulva.

Gentlemen: This woman had her first labor twenty-five years ago, and is now fifty years old. She lived then in the country, and was four miles from the nearest physician. She fell into labor—her first and only one—with a shoulder presentation. Much delay took place before the doctor reached her side, and then he found that the waters had escaped, and the shoulder was so jammed down that he could not perform version. He sent for help, and two brother physicians came to his aid; but they also found it impossible to turn the child and deliver the woman. By this time many hours had elapsed, and while they were debating the propriety of performing embryulcia, the child was turned and delivered by the rare mechanism of spontaneous evolution. Of course the child was dead; but that was not the only misfortune; for the bladder and the surrounding pelvic tissues and organs had been so seriously compressed as to cause sloughing of the womb, the whole base of the bladder, the entire track of the vagina, and all of the urethra. The vagina nearly closed up by cicatricial contraction and the urine was constantly dribbling from her person, making her very raw, bad smelling and miserable. She consulted eighteen physicians; but nothing could be done for her. Finally she came to me in 1877; and I performed the following operation with her consent, telling her that I did not know whether it would succeed or not. It consisted in making an opening between the vagina and the rectum—in other words, a recto-vaginal fistula. Then I closed up the whole vulvar opening, and thus converted the rectum into a bladder. At first the rectum so resented the presence of the urine, that she had to pass her urine every few minutes, and I was afraid that I would be compelled to reopen the vulva. But finally rectal tolerance took place, and she became able to hold her water in the rectum for six hours at a time.

For thirteen years she got on very well; but a few months ago, probably through something undigestible which she had swallowed—perhaps a bone—a small fistulous opening occurred near the arch of the pubic bone, from which the urine dribbles. So she has come to-day to have it closed up. She is an opium-eater, and she looked so pale that I had her urine examined. Much albumin was found; but whether it is secreted from her kidneys, or comes from the admixture of feces in her urine, I cannot say. But we shall take additional precautions while administering the ether; for ether is obnoxious to diseased kidney, especially when caused by compression from large tumors; and we may then have arrested secretion as a result. Under such a circumstance, namely, the presence of a large tumor, I usually give chloroform.

The operation to-day will consist in simply freshening the sides of the sinus, and then bringing the raw edges together. My assistant has just syringed out the fistulous track with a 1 : 2,000 sublimate solution, preparatory to the operation. But he forgot that the vagina communicates with the rectum, and that this antiseptic solution, while quite harmless in the vagina, is capable of doing much mischief in the rectum. So we wash out the rectum with large quantities of water, and thus get rid of the danger of having the poison absorbed.

This episode reminds me of another,

which filled me with great anxiety at the time, but at which I can now laugh heartily when I think of it. Early last summer I removed a malignant growth from the cervix uteri of a woman and ordered daily douches of a 1 : 2,000 solution of corrosive sublimate: that is to say, a tablet of seven and a half grains of corrosive sublimate was put into a quart of water which was injected by the nurse into the vagina. As the patient convalesced, she would sit on the commode and would herself insert the nozzle of the syringe into the vagina. But on one extremely hot evening she unconsciously introduced the nozzle into the rectum. The nurse, not knowing how very much astray the nozzle had gone, pumped away until very nearly the whole quart had been taken up. Suddenly the woman began to feel severe rectal pain, and then she realized what she had done. The nurse, although very greatly alarmed, was quite equal to the emergency. She sent in great haste for me, and at once injected quart after quart of water until the lower bowel was well washed out. I hurried the messenger to the nearest drug store for lime water, and then ran all the way to my patient's house, which was nearly half a mile distant. A quart of lime water was now thrown up into the bowel, as an additional precaution; but it was hardly necessary, as the previous repeated injections by the nurse had carried off the poison. Beyond a slight soreness of the rectum, which lasted for twenty-four hours, my patient suffered nothing. But what with the heat, the anxiety, and my hard run, my undercloth-ing became so drenched with perspiration that I had to change them all when I reached home.

But, to return to our patient. It sometimes happens in these cases of violent injury to the soft parts from labor, that menstruation is permanently arrested. Exactly why this happens, I cannot say; but so it was with our patient when I operated on her in 1877; and I have repeatedly seen it in other cases. In one of these cases—that of an unmarried girl—I never could find the cervix uteri, so destroyed and matted together were all the pelvic organs from a neglected labor. Twice, in vain efforts to discover it by dissection, I got into the peritoneal cavity. As she had lost the whole base of her bladder, and also had a very large recto-vaginal fistula, caused by the general sloughing, I closed up her vulva, as in the patient before you. In her case also, the rectum needed education to tolerate the presence of urine. But ultimately it made a very good bladder. If my memory is not at fault, these are the only two cases in which I was forced to close up the vulva. I have, however, on one occasion closed up the womb, or rather the cervix, in the bladder, so that the woman menstruated afterwards into the bladder and out through the urethra.

While talking, I have been denuding the edges of the fistula. These are coaptated by shotted wire sutures. In order to avoid all tension on the parts by the accumulation of urine in the vagina, I shall insert a short catheter into the rectum. These sutures will not be removed for at least a week; but if there should be a leakage from the wound they will be kept in for two weeks, so as to aid the granulating surface to close up. The wire used was No. 31, which is the finest used in gynecological work. My rule in the selection of wire is, to use the finest compatible with safety—the finest for plastic operations on the cervix and on the bladder; the heaviest for perineal tears.

The lesson which we get from this case is to act promptly in obstetric emergencies. My rule is always to interfere, and that promptly, in certain conditions. For instance, in a face presentation, if the occiput cannot be brought down to become the presenting part, I always turn. In a breech case, I make it the rule to bring down one leg; and I thus have the labor wholly under my control. In a shoulder presentation I always give ether, and turn as soon as possible, by the bimanual, or bipolar, method. The most common cause of vesico-vaginal fistula is delay in a head-first labor, after the engagement of the head. Therefore this lesion is more likely to happen in cases of moderate disproportion than in extreme ones; for in the latter the head cannot engage, and it has to be opened before it can delivered.

Medicinal Treatment of Fibroid Tumors.

I expected to operate before you upon this case; but, upon thoroughly examining this woman and learning her history, I have decided not to do so; I have changed my mind and come to this let-alone treatment for some reasons which I wish to impress upon you. The patient is an unmarried woman, forty-two years old, and was beginning to go as long as seven weeks without seeing her menstrual periods, when, not

long ago she began to menstruate profusely every three weeks, or, at least, to have severe hemorrhages from the uterus at these intervals. A few weeks ago her physician discovered, and informed her that she had a tumor of the womb; and she, woman-like, wished to "have it taken out at once," and gave him no peace until he brought her to me. So by agreement I came over to see her yesterday and decided not to operate, or, at least, not to operate now, as I shall presently explain to you. She is forty-two years old; therefore, approaching the climacteric, and her monthly periods had begun to dodge, before these violent hemorrhages set in. Now what causes these floodings? Usually one of only two diseases: either a cancer of the cervix uteri, or a uterine fibroid. If she had been the mother of children, the probability would be that she had a cancer; because this disease usually comes from a cervical tear. But as our patient has never had a child, the tumor turned out to be a uterine fibroid, as under such circumstances it usually does. Old maids and sterile women are very liable to have fibroid tumors of the womb, and very unlikely to have a uterine cancer. Yes, I fully agree with the diagnosis of her physician. She has multiple fibroid tumors of the uterus. There are, at least, three of them that are sub-peritoneal and attached to the left side of the womb. By them the uterus has been pushed over to the right side, and the left ovary is probably much dislocated in relation to the surrounding parts. Now, if any operation were performed, it would have to be one of two, either of which would be difficult and dangerous. The more common of these two is oöphorectomy, with the hope of stopping menstruation and thereby relieving the certainly periodical, and more or less constant congestion of the womb. But this operation would probably be difficult, if not impossible, on account of the size of these multiple tumors. For, sometimes the ovary in these cases has no pedicle, as it is drawn down in close relation to the tumor. Sometimes it is stretched to a mere ribbon or a mere cord several inches in length. Sometimes, indeed, it is so imbedded in the tumor as not to be enucleated safely. The other operation would be the removal of the whole mass—womb, tumors and appendages. But there is some risk attending this operation—a risk to life which her condition does not warrant. Moreover she does not live by manual labor, and therefore she can take care of herself until the change of life takes place, which will bring about the cure of her disease. Nature cures, by causing atrophy and absorption of these growths, whose nutrition is interfered with by the cessation of menstruation.

To tide the woman over to that time, needs some treatment. As she has plenty of fat and blood, she is to have her bowels kept open by saline cathartics; such as Rochelle salts, Seidlitz powders and citrate of magnesia. Then she is to take after each meal twenty drops of the fluid extract of ergot and ten grains of ammonium chloride. The effect of the ergot will be to contract the muscular fibres of the uterus, and thus, by compressing the vessels, to lessen the blood supply of the tumor. Sometimes the womb contracts so firmly as to squeeze the tumor out of its uterine nest into the uterine cavity and expel it per vaginam. The ergot may cause headache, vertigo and nausea, through vasomotor disturbance; and then the dose must be reduced, but not discontinued wholly. The ammonium chloride acts as a resorbent, and clinches the action of the ergot. For continuous treatment, it should not be given in tablet form; as it is likely then to settle itself in one portion of the stomach and dissolve there, irritating the mucous coat of that portion. Give it largely diluted in water, and then it will mix with the contents of the stomach and get still further attenuated. This treatment by ergot and ammonium chloride should be continued for months. I have seen great results follow the continued use of these medicines. The hypodermic administration of ergotine is still more efficacious; but it gives so much pain, so discolors the skin and is so liable to be followed by abscesses or very painful indurations, that I now rarely resort to it.

Homœopathy in Russia. — Homœopathy is said to be spreading in Russia, especially in the upper social strata. Societies for the propagation of the Hahnemannian doctrines have recently been established at Tschernigow, Odessa and Warsaw. As has been noticed in other countries, the clergy are conspicuous among the supporters of the great medical heresy, and in Russia the military mind seems also to have an elective affinity for globules and infinitesimal dilutions. At Tschernigow, one of the founders of the new Society is a Bishop.

HYDATID CYST OF THE LIVER.—PLEURISY ASSOCIATED WITH TUBERCULOSIS.[1]

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Obstructive Jaundice Due to a Hydatid Cyst.

Gentlemen: A little sooner than I anticipated I am able to demonstrate the morbid anatomy of the case of obstructive jaundice I brought before you last week. You no doubt remember the patient, whose previous history we did not know, except that his jaundice was of a moderately chronic duration, lasting for two months. The fact that he was jaundiced because of obstruction to the bile ducts was plain enough, the question was as to the cause. Without any definite data to sustain us, we came to the conclusion that his condition was due either to carcinoma of the biliary passages, or to their obstruction by gall-stones. In speaking of some of the causes of obstructive jaundice, you will remember that I referred also to hydatid cysts, and round worms as very rare causes of such a condition, so rare that one would hardly be justified in making such a diagnosis except by the most positive exclusion of the other causes of jaundice. You will also remember that I suggested that the question could be solved by means of the exploratory needle and by laparotomy, but that the patient was so ill that these means were scarcely justifiable. Moreover, his blood was so seriously poisoned by the retention of bile, that on this account an operation would not be justifiable, since the patient would probably die of hemorrhage, either from a copious escape of blood at once or from constant oozing. The fatal termination resulted four or five days afterwards, his stupor deepening into coma and death.

The autopsy showed a very remarkable state of affairs. There was no disease outside of the ducts or liver. The tissues and structures showed simply an impregnation by bile. The large common duct was very much enlarged, exceeding the size of my thumb. It could be readily distinguished from the vein alongside of it, and was easily isolated. There was not a sufficient amount of adhesions to cause any doubt as to the relation of the parts. The gall-bladder was enlarged, and distended with a mucoid fluid. That portion of the duct extending from the cystic duct to the duodenum was patulous. The biliary ducts in the liver were dilated, and just above the entrance of the hepatic duct into the liver there was a large dilatation, apparently of the duct, but which I believe to be a cyst which had ruptured into the duct and in that way occluded the canal with the hydatid membranes. The duct itself was not the seat of any disease. This cyst, hydatid in nature, was large enough to hold a good-sized lemon. There was a second cyst whose contents still remained in the periphery of the left lobe of the liver. It had nothing to do with the cause of the jaundice. The contents of the larger cyst, by causing an obstruction of the duct, had given rise to the jaundiced condition of the patient. These large shreds of membrane, which I here show you, could never have passed through the duct into the duodenum. Nature made an effort to accomplish this, but was not able to sufficiently distend the duct.

The question now is, could this man have been relieved by an operation? I think he could, because of the size of the duct. There were so few adhesions that access to the ducts could have readily been had and a cholecystotomy performed relieving the obstruction, while a rubber tube would have drained the cyst, and the patient would probably have recovered. Of course there would have remained the other cyst, which would gradually have increased in size; and, knowing this history of the patient, a second operation could have been performed, either by laparotomy or aspiration. The patient just missed his chance of recovery by not entering the hospital a few weeks earlier.

The lesson we learn from this case is, that an exploratory operation in obscure cases of obstructive jaundice is always advisable. Opening the gall-bladder simply, would not have been of service here. The mucoid contents of the bladder simply indicate that there is an obstruction of the cystic duct, and that the gall-bladder has merely become a large retention cyst, the removal of which would not cure the disease. The fact that this man died of an hydatid cyst of the liver, the contents of which obstructed the duct, would never justify you in making such a diagnosis. It is very probable that never again will you see an instance of such

[1] Delivered at the Philadelphia Hospital.

a condition, unless you settle in some country where it is common, as in Australia or Iceland or perhaps northern Minnesota, in our own land.

Pleurisy with Tuberculosis.

I wish now to call your attention to this patient. He is a slight, delicate-looking young man, 20 years old, a stone-cutter by occupation, who has been much exposed to changes in the weather. His ailments in childhood were not unusual, and his habits were not bad. He has used alcohol moderately. There is nothing peculiar in his family history, and we can find but very little about his residence and his associates—an important point to learn in suspected cases of developing tubercular disease. On the thirteenth of July after doing some heavy lifting, he noticed that he was short of breath. About the same time his work was such that he was frequently chilled and wet through. This shortness in the breathing continued, and was attended with a slight amount of coughing, only noticed on stooping. At the time this cough was most severe, he had a pain in his right side, but none in the left. On July 29, he was obliged to quit work, and was admitted to the hospital on August 12, exhibiting these symptoms: great dyspnœa, especially on walking about; respiration increased somewhat, but not greatly—28 to 34 per minute—cough and fever with great depression and prostration.

Here we have a case of a sub-acute illness with the symptoms pointing to some disease of the chest, occurring in a lad who has been so much exposed that we are led to suspect some form of pulmonary disease. Throughout the whole time since his admission he has had fever, and he has also lost flesh to a moderate degree, while he suffers with night-sweats and great prostration. Note, therefore, in the first place, the gradual onset of the disease, and in the second place, the lung symptoms associated with fever, emaciation—not rapid—and night-sweats. We will now proceed to an examination of his chest.

His respirations, you will notice, are hurried, and there is some flatness on the right side of his chest, with fulness on the left. The lower part of the right side expands, while the left base scarcely moves. On palpation there is found a diminution in the vocal fremitus on the left side, with normal fremitus upon the right. On percussion, there is found dulness in the left second interspace, increasing to flatness further down, with tympany over the gastric area. The right side shows normal pulmonary resonance. On auscultation, I find diminution in the breath sounds upon the left side, with a somewhat exaggerated respiratory murmur on the right side, puerile or bronchovesicular in character. We have here a unilateral increase in the size of the chest, which means a unilateral increase in the amount of its contents. Unilateral diminution in movement shows a diminution in the amount of air there, which is also shown by the absence of normal pulmonary resonance. We are able, therefore, from inspection, to eliminate the fact that this enlargement is due to some enlargement of the lung, since, if due to compensatory emphysema—the usual cause of such an enlargement—there would be an increased amount of air, with exaggerated movement of the chest. That it is in the pleura that we have this increase in the contents, is shown by palpation and in the absence of vocal fremitus. There is something here that prevents the vibration of the voice from reaching the hand. Without doubt, this is a pleural effusion.

We must determine now the character of this fluid, and the cause of the effusion. As to the nature of the fluid, we may learn this either by direct exploration, or by a further study of the physical signs. Serum, blood or pus may be present in the chest. If serum, the symptoms are such as you see present in this case; there are no physical signs by which we can determine the presence of blood from serum; but when pus is present we have the sign of Bacelli to rely on, that is, no transmission of the whispered voice. In this case a hypodermic needle has been used for diagnostic purposes, and a small amount of serum has been withdrawn. Such a procedure must be carried out with care, since, unless done antiseptically, empyema will result.

There are general and local causes of pleural effusion. The heart, kidneys and blood are free from disease, and thus the usual causes being eliminated, we are driven back to the pleura itself in investigating as to the cause of this condition. We learn that the disease developed insidiously, with shortness of breath, slight cough and fever.

Therefore, associated with this local symptom of serum in the chest, we have fever, emaciation and night-sweats.

As an aid to our discussion let us ex-

amine a similar case of effusion, with different general symptoms. Here is another well-appearing man who presents similar local symptoms and signs, which are not so marked as in this young man. There is lessened movement of his chest, slight fulness of the intercostal spaces, dulness on percussion, not very high laterally, and posteriorally beginning at the middle of the scapula and ending in flatness at the base, with absent breathing sounds. He has also slight shortness of breath, and slight pain; but otherwise he is not suffering at all. At times you will see such cases presenting no general symptoms; and if you are not careful to examine the patient all over from time to time, such a condition will often be overlooked. It is a very common thing to find cases of pleural effusion developed insidiously. As soon as the effusion takes place all pain disappears, and the patient may not lay much stress upon the slight pain present at first and lasting only a short period. Why, now, is there such a difference in the symptoms of these two cases? It must be due to a difference in the cause or to a difference in the character of the effusion. It is not due to the amount of fluid present; for this will have no effect upon the fever, emaciation and sweats.

Pleurisy with fever, when of long duration, is due to associated complications, to the peculiar nature of the effusion (purulent), or to a difference in the cause. Is there any specific process which is the cause of this condition in this lad? Is there any septic process here? A woman after confinement will have a chill, irregular fever, and a stitch in her side, a true pleurisy due to septicemia or pyemia. There is nothing like this here. There is no suppuration in any part of the body which would cause septicemia. In cases of tuberculosis, which is another true microbic process, pleurisy, like inflammation of other membranes, is apt to occur. Indeed many believe that pleurisy never occurs except of tubercular or septic origin. Is tuberculosis present in this instance? We have not been able in one examination to demonstrate the presence of bacilli in the sputum or serous exudation. It does not follow that tuberculosis is absent. The micro-organisms may be present in small numbers, and be detected only after frequent examinations. There is, however, undoubted tuberculosis at the apex of the right lung. The physical signs—upon which time will not permit me to detail—show this. The co-existence of this process in the right lung, with the fever, emaciation and sweats, are sufficient to warrant a diagnosis of tuberculosis.

The points to remember here are: the ofttimes insidious onset of pleurisy and its association with tuberculosis.

The treatment of the case varies with the cause. In acute pleurisy with effusion the saline treatment is of service; but in this kind, with fever and prostration, we do not use such depletive measures. The fact that tuberculosis is associated with pleurisy does not compel us to make a fatal prognosis. Tubercular disease of serous surfaces is the most favorable form of the disease. Aspiration, or removal of the fluid in tubercular peritonitis, will often cure the disease; and so aspiration of the pleural sac will favor the cure of such cases. This should be done frequently.

COMMUNICATIONS.

CASE OF OVARIOTOMY.[1]

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Fifty years ago, when the operation for the removal of an ovarian cyst was revived by the late Dr. John L. Atlee, of Pennsylvania, and his associates, and for years and years following their renewal of the operation, the man who was courageous and heroic enough to enter the abdominal cavity with the knife was indeed noted and eminent among his confréres. To-day, with the advance in science and surgery, the doctor who has *not* successfully performed a laparotomy is the one who stands noted among his colleagues. Indeed, so very common are the reports of the operations of laparotomy and ovariotomy, that I would not venture to report this case were it not that there are several features connected with it that I have never known to occur before, and which I think will make the report of interest.

In May, 1889, I was called to see Mrs. L., white, 21 years old, married two years, without issue. She menstruated at the age of fourteen, and continued regular. Directly after her marriage, she noticed an en-

[1] Read before the Tri-State Medical Association, October 16, 1890.

largement in her left side, which gradually increased until it became so considerable as to impede locomotion and interfere with respiration. Because of this preying upon the vital sources of the system, and because of the indigestion, which was a prominent symptom, I found my patient greatly emaciated and weak. Upon examination, I diagnosticated a multilocular cyst of the left ovary, and appointed May 15, two weeks later, as the time for operation. On that day I found her with a pulse of 120, her temperature 103°, and her respiration very rapid, and with these symptoms I thought it best not to operate. Upon her earnest solicitation, and that of her family, for some immediate relief, I performed paracentesis, and drew off thirty pounds of a thick, coffee-colored fluid, albuminous in character, and presenting under the microscope the ovarian germ of Drysdale. The operation gave her great relief. On May 25, ten days afterwards, I operated, being assisted by my son, Dr. James H. Atlee, Dr. Force, of Calhoun, and Dr. Richardson, of Charleston, Tennessee, and removed by abdominal section a tumor weighing forty-five pounds, which in every way confirmed my diagnosis. The pedicle, which was short and thick, I secured with two ligatures, before severing the tumor: using one for each half of the pedicle. The ligatures used were Snowden's iron-dyed black silk ligatures, No. 14. After the tumor was severed, there was a profuse hemorrhage, due to the retraction of the artery from the ligature. Another ligature, cast around the stump, secured the artery and stopped the hemorrhage. After thoroughly cleansing the abdominal cavity with warm carbolized water, the divided edges of the peritoneum were brought together with catgut ligature, and the abdominal wound was closed with the iron-dyed ligature, with a drainage-tube of rubber in the lower portion.

The case progressed without a single unfavorable symptom, with adhesion by first intention. About the eighth week after the operation, symptoms of cystitis appeared, with difficult and painful urination. The urethra was found to be closed with an object, which, upon removal, was identified as one of the ligatures used in ligating the pedicle. Following the removal of the ligature from the urethra there was a flow of bloody pus and urine, with a subsidence of all disagreeable symptoms and a speedy recovery.

About the sixth month after the operation cystitis re-appeared, and gradually increased in severity until the second ligature was passed from the bladder. This ligature I have now in my possession. The passage of this ligature was, in a like manner, followed by a flow of bloody pus and urine, and the rapid abatement of all symptoms of cystitis. Since then my patient has remained in perfect health, and is now a stout, strong, healthy woman, busy with the duties of her household.

The interesting feature of this case is the passage of the ligatures from the peritoneal cavity, through the peritoneum and the walls of the bladder and through the urethra. I have no recollection of an ovariotomy that has progressed just as this one did, with the passage of the ligatures through the walls of the bladder and urethra, at the same time occasioning no inflammation of the peritoneum, no escape of urine into the peritoneal cavity, and no cystitis sufficient to endanger the life of the patient.

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CARCINOMA OF THE GALL-BLADDER AND LIVER FROM BILIARY CALCULI.

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Carcinoma of the liver is, in three-fourths of the cases, secondary, the primary growth occurring in the stomach, intestines, pancreas or mesentery, and being communicated to the liver either by direct extension or by metastasis. Carcinoma of the gall-bladder, extending into the liver, is comparatively rare. Such a carcinoma is the result of the formation of a mass of gall-stones in the gall-bladder, this causing attacks of inflammation and adhesions forming between the liver and the gall-bladder, which become the seat of carcinomatous growth. Carcinoma of the liver is usually nodular, forming a more or less spherical mass protruding from the surface of the liver and changing its shape. When extending from the gall-bladder, it infiltrates the liver substance, giving an even enlargement. The usual form of growth is of the encephaloid type, cell-nests predominating over fibrous tissue.

The following report describes a case of

carcinoma of the gall-bladder extending into the liver, occurring with no previous attacks of biliary colic or other symptoms pointing to the formation of a mass of gall-stones. That a mass of over twelve hundred stones, some of them of considerable size, could form without giving rise to symptoms sufficient to attract the patient's attention, seems almost impossible.

E. M. was seventy-nine years and eleven months old at the time of her death. The family history was very incomplete. Two sisters had died of cancer—in what situation was not known. The patient had had several children who, at the time of her death, were all living and healthy. She could give no history of any past illness more severe than constipation, and had never had biliary colic. She was seen first at the Dispensary of the New York Infirmary for Women and Children, July 2, 1889. She then complained of having had, for about two weeks, nausea, pain and fulness in the stomach after eating. Her tongue was coated and her bowels constipated. Simple gastric remedies relieved her, and no physical examination was made. She came again January 2, 1890. She then complained of the same symptoms as before, but had also a lancinating pain over the liver running through to the back. She stated that she had had this pain for three months, and had not been feeling as well as usual for a year. Examination of the abdomen showed the liver to be enlarged, projecting a finger's breadth and a half below the border of the ribs in the nipple line. The edge was smooth and hard. Below the liver, and attached to it, but separated from it by a sulcus, was a mass the size of a man's fist, which felt distinctly nodular through the lax and thin abdominal wall, and of stony hardness. This mass was tender on pressure, and was the seat of the lancinating pain complained of. The other abdominal organs were normal, as were also the heart and lungs. The urine was stated to be scanty and contained no albumin, but a few granular casts. The patient was thin, but not cachectic. She had simply the look of poor nutrition, so familiar at dispensaries.

A diagnosis was made of carcinoma of the liver, probably secondary to a deposit in the pyloric end of the stomach or duodenum. The patient continued to visit the clinic up to about February 1, when she became unable to leave her house. She frequently located her pain in the epigastrium, instead of over the liver. She had no vomiting and no jaundice. The bowels were constipated throughout her illness. The stools contained, at times, blood and mucus, and were never clay colored.

By February 8, the patient had acquired the cancerous cachexia, was weak and much emaciated. The pain had increased much. On February 13, vomiting occurred for the first time.

The vomited matter contained no blood. The urine showed a small amount of albumin, but no bile pigment. It deposited a very heavy precipitate of urates. The tumor had increased much in size, and was extremely tender. It seemed now to consist of two distinct masses, separated by a deep sulcus. The spleen was of normal size.

On February 20, the patient's temperature was 100.4°. The patient's mind had not been clear for several days, she was delirious during the previous night, and remained in a semi-conscious state. She complained of pain in the epigastrium, but not over the liver. The tumor had been enlarging rapidly, and now reached the umbilicus, and the liver extended down over the lower mass.

February 21, she had marked fever; the skin was slightly jaundiced; but there was now no complaint of pain. Her urine had a specific gravity of 1.029, was dark brown in color, giving a marked yellow froth on shaking, and a play of colors with the sulphuric acid and sugar test. It contained a trace of albumin.

February 22, the temperature was 99.8°, and the woman had severe pain over the liver and was deeply jaundiced.

On February 23, she had a succession of chills, lasting all day, and towards evening became very feverish. She suffered intense pain, so that she cried out and flexed the legs on the abdomen. On February 24, the pain had passed off, but she remained semi-conscious, and died early on the morning of February 25.

An autopsy was made by Dr. Walter Vaught. The lungs showed a few milliary tubercles at the left apex and firm pleuritic adhesions on the right. The heart was normal. The pancreas, spleen and kidneys were normal. The stomach—the suspected seat of primary carcinoma—was normal. The jejunum and ileum were normal. The colon was crowded with hard scybalous masses of feces, but entirely free from carcinoma. The right lobe of the liver projected two finger breadths below the border of the ribs. The

anterior surface of the right lobe over the region of the gall-bladder was of stony hardness; the left lobe was normal in size. Projecting from the lower surface, in the location of an enlarged gall-bladder, was a hard nodular mass, the size of a man's fist, firmly adherent over its entire upper surface to the liver. In cutting into this mass, the gall-bladder was opened and showed the mass to be composed of gall-stones of all sizes, firmly pressed together and forming a single mass, which was not easily broken up until the incision in the gall-bladder had been lengthened. After removing the stones, the walls of the gall-bladder were seen to be infiltrated with cancerous material, which had extended into the substance of the liver. The mass in the liver formed a patch about the size of the palm of a man's hand, varying from one-quarter inch to one and one-half inches in thickness, smooth and not nodular. The substance was firm and of a white or pinkish color on section, contrasting with the deep color of the congested liver tissue. All the bile ducts were in a state of suppuration, and filled with a mixture of pus and bile. The mucous membrane of the gall-bladder was ulcerated in many places. One ulcer had perforated the wall of the duodenum and formed an opening the size of a five-cent piece. In the cystic duct, at its junction with the hepatic, was found a gall-stone, the size of a filbert and firmly impacted. This entirely prevented the passage of bile into the intestine, and as jaundice did not occur until four days before death, the stone must at that time have reached its position at the junction of the ducts, and the severe colic on the day before death was probably due to its attempt to pass down the duct. That the duct must have been partly occluded four days before death is shown by the beginning of jaundice at that time. This caused the suppuration of the bile ducts and the fever and delirium of the last few days. Several inches of the duodenum were included in the cancerous mass, all being firmly matted together. The lumen of the intestine was in one place contracted so as to admit only the tip of the finger. A section of the cancerous mass in the liver showed cell-nests filled with large cells and separated by a more or less scanty stroma. The deposit had occurred by infiltration directly from the adherent gall-bladder.

The gall-stones were of three distinct kinds. There were about a dozen the size of a filbert and of a whitish color. The remainder were of a dark-gray with a yellowish surface easily flaked off by the nail. There were four hundred, varying in size from that of a small French pea to that of a hazel nut. Besides these, there were a large number of smaller ones, like fine granular sand. Of these eight hundred were counted and many were lost. They appeared to consist of cholesterin, variously colored by bile pigment and were very hard.

While years must have been occupied in the formation of this mass of gall-stones, they had produced no biliary colic, and had never caused sufficient irritation to attract the attention of the patient or of any physician, until the growth of the cancer, five months before death.

160 East Thirty-sixth street, New York.

PERISCOPE.

Diabetic Coma.

The *Lancet*, November 8, 1890, says: Dr. R. Schmitz, of Neuenahr, in Germany, has had a large experience in the treatment of diabetes, and therefore his opinion on diabetic coma is to be regarded with interest. He states that under the term "diabetic coma" two distinct conditions are to be recognized, both of them serious and somewhat similar at first glance, but entirely different as regards their pathology, and requiring different modes of treatment. The first is simple collapse, with coma; the second is an auto-infection, and is diabetic coma properly so-called. By most observers it is ascribed to the condition of acetonuria. The collapse is the result of weakened heart power, brought about by an excess of sugar in the blood causing a general degeneration of the muscular tissue throughout the body, in which the heart participates. During collapse there is marked cyanosis, the respiration is quickened, the pulse is generally about 68 to 72 a minute, the temperature is not raised, the heart's beat is almost imperceptible and the first sound can scarcely be heard. The treatment of this condition, according to circumstances, is prophylactic or active. If the cardiac degeneration is recognized before collapse occurs, the patient must be particularly warned against any violent exertion, cardiac depressants (such as the bromides or antypyrin) must be avoided, but in addition to the ordinary diabetic treatment

a little alcohol should be added to the diet, and the patient should be out in the fresh air as much as possible. During the actual attack stimulants must be employed, of which the best are black coffee, castor oil and hypodermic injections of camphor and musk. In true diabetic coma there are generally well-marked prodromal symptoms—complete loss of appetite, somnolence with unrefreshing sleep, etc. The tongue becomes coated and dry, the breath very fetid. When coma sets in there is fever (100° to 102° F.), respiration and pulse are quickened, the former rising to 45 and the latter to 130 a minute. There is much epigastric pain, but there is no tenderness. The diagnosis is easy and is based on the epigastric pain and rise of temperature (both of which are absent in the first form), on a negative result from an examination of the heart, and on the rapidity of the onset of the coma. The treatment is directed to the removal of the toxic material, which Dr. Schmitz considers accumulates in the intestine. He consequently advises frequent doses of castor oil, even if diarrhœa be already present. He orders half an ounce every hour until a full evacuation is produced, and states that he has had excellent results from this method of treatment.

Salinaphthol in Rheumatism.

Salinaphthol is a combination of salicylic acid with naphthol, and is analogous to salol, which is a combination of the same acid with phenol. It is insoluble in water, and has neither odor nor taste.

In a review of salinaphthol, the *Journal de Médecine*, November 9, 1890, says that the remedy seems to act as well as salol in acute articular rheumatism, and it is well borne. In the dose of five and one-half to seven and one-half grains, repeated four times a day, it produces neither headache, ringing in the ears, nor any symptom of poisoning, even after prolonged use. Kobert claims that it is separated into salicylic acid and naphthol by the pancreatic juice and by the ferment which the intestinal mucous membrane secretes, and that this separation is evidenced by the presence of salicylic acid in the urine. Lépine denies that the separation takes place from the action of the intestinal juice, and admits such separation only as the result of the action of the pancreatic juice. There is here room for fresh experiments to examine whether or not the pancreatic juice really has this action, and if it is not the same for salinaphthol as for salol, which is decomposed not only by the pancreatic juice, but also by the alkaline constituents of the blood.

Salinaphthol should be less harmful than salol, since naphthol is less toxic than phenol. But, up to the present time, clinical experience does not seem to have established the efficaciousness of this medicament.

Railway Readers.

The *Lancet*, November 8, 1890, says: a contemporary recently stated that a French medical practitioner has been collecting statistics with regard to those of his patients who complain of nervous affections, and has come to the conclusion that all the evil proceeds from the practice of reading in the train. We can hardly accept this view. Many thousands of business men have no other time than the half or three-quarters of an hour to learn the state of the markets, the last moves in the politics of the great Powers, general news, and the various items that make up the contents of a morning or evening paper, and it would hardly appear that the duration of the cause is sufficient to produce the effects assigned to it, whilst the majority of people travel too rarely and read to little to suffer at all. Our contemporary suggests that a paper with specially large type should be printed for the use of travelers by rail. We fear it would prove of little service. We suggest that all carriages should, as a general rule, be supplied with a better light.

Ergotin in Gleet.

In the Polish periodical, *Wiadomosci Lekarskie*, No. 8, 1890, p. 250, Dr. A. Roicki highly eulogizes ergotin as a means for rapidly curing chronic gonorrhœa. The drug should be simultaneously used, both internally, in pills, and locally, after the following formula.

℞ Ergotini . . . . . 0.3 gramme
Aquæ destillatæ . . . . . 300.0 grammes
M. D. S. Inject a syringeful into the urethra several times a day.

The injections are said to be tolerated perfectly well. The same treatment proves useful in cases of urethral hemorrhage.

THE

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Make communications as short as possible.
NEVER ROLL A MANUSCRIPT! Try to get an envelope or wrapper which will fit it.
When it is desired to call our attention to something in a newspaper, mark the passage boldly with a colored pencil, and write on the wrapper "Marked copy." Unless this is done, newspapers are not looked at.
The Editor will be glad to get medical news, but it is important that brevity and actual interest shall characterize communications intended for publication.

THE END OF THE YEAR.

A PRIVATE WORD WITH OUR READERS.

During the past year the columns of the REPORTER have contained—as will be seen by looking over the Index and the list of Contributors—a large number of scientific papers of great value from men deservedly eminent in the profession and from many others of less extensive reputation, but who are careful observers and skilful practitioners. The practical value of the papers submitted for publication has always been regarded as the best criterion of their usefulness. Especial attention has been bestowed upon the feature of Clinical Lectures; because it is believed that many readers like to hear what they would be hearing if they were again in the schools where the art of medicine is taught. The Department of Correspondence has covered a large number of American and foreign cities, and has included short communications from readers of the REPORTER in every part of the world. The Selections, Translations and Abstracts have been made with great care, and their source has been fully stated, so that proper credit should be given to those of our contemporaries from which they have been taken, and so that any reader might go at once to the original if he wished. The Editorials and Book Reviews, written by the Editor and a number of men especially competent in various departments of medicine, have always been prepared with an eye single to the good of the reader. No interest, no friendship has been allowed to stand in the way of honest criticism; and no praise has been insincerely uttered.

The purpose of the REPORTER is to be a journal wholly and fearlessly devoted to the advancement of the medical profession, and an alert and conscientious friend to every one who consults its pages. This purpose will shape its policy in the year upon which we are about to enter, and in which we hope all the readers of its pages may be abundantly prospered.

HYSTERIA IN MALES.

In a communication to the *Archives de Médecine*, August, 1890, Dr. A. Souques reports thirteen cases of hysteria in men which he has seen in the Broussais Hospital. From an abstract of this paper in the *Bulletin Médical*, October 1, 1890, we learn that Souques thinks that hysteria in the male is by no means uncommon, that it is encountered frequently in ordinary hospital practice, and that it may be more frequent in the lower classes than hysteria in women. The patients he observed were from twenty to fifty years of age, and were nearly all working men, while some of them were in actual destitution. According to Charcot, such persons are more subject than

others to the causes which sometimes give rise to hysteria, such as traumatism, intoxications and infectious diseases. Souques found the cause of hysteria in his cases to be lead poisoning eleven times, traumatism three times and once each syphilis, dysentery and alcoholism. But there must also be an hereditary nervous tendency.

The symptomatology of hysteria in males is variable. Often the onset is marked by an apoplectiform attack, more often, perhaps, by vertigo, dazzling sensations and a disposition to faint. Vertigo appears to characterize hysteria in the male very much as convulsions do hysteria in women. The most frequent motor troubles of hysteria in males are paralyses, while anæsthesia, limited by the median line of the body, are common. In general demeanor a female hysterical patient is usually gay and lively, while a male is likely to be sombre and gloomy. Hysteria in males is a relatively mild disorder; and usually it terminates favorably. The motor troubles are the most rebellious, and the prognosis in regard to them should be reserved. The patient will probably recover, but it cannot be said at what time. The possibility of relapses should be borne in mind.

The treatment of hysteria in males should be directed to both the hysteria and the provoking cause.

Those who feel interested in the subject of hysteria in men will be interested, we think, to know that Dr. Julius Dreschfeld has an excellent article, "On some of the Rarer Forms of Hysteria in Man" in the *Medical Chronicle*, October, 1890. Dr. Dreschfeld takes almost precisely the same view of the etiology of this disorder as does Souques—who appears to have adopted it from Charcot—and reports four cases which differ from those usually observed after shock and injury. The first two cases belong to the group known as spurious hydrophobia or pseudo-hydrophobia. They are similar to cases familiar to all who have made a thorough investigation of the literature of hydrophobia, and—aside from their intrinsic interest—would prove instructive to persons unfamiliar with the disorders which simulate hydrophobia.

The whole subject of male hysteria is one of great interest, and we think it is one in which there is still room for much investigation. The name is unfortunate; but until a better one is suggested it will have to serve to indicate what is now generally—though vaguely—understood by it.

A KOCH INSTITUTE IN NEW YORK.

In striking contrast to the attitude of caution which all scientific medical men are observing towards the Koch remedy for tuberculosis, it was announced on December 21, that a "New York Bacteriological Institute" had been incorporated for "the study and gratuitous treatment of contagious diseases, comprising a Pasteur and Koch department for the treatment of hydrophobia and tuberculosis." In the list of Trustees, the observant reader will not be surprised to find the names of Drs. Gibier and Liautard.

BOOK REVIEWS.

[Any book reviewed in these columns may be obtained upon receipt of price, from the office of the REPORTER.]

CYCLOPÆDIA OF THE DISEASES OF CHILDREN. EDITED BY JOHN M. KEATING, M. D., Volume iv. Large 8vo, pp. xii, 1128. Philadelphia: J. B. Lippincott Company, 1890. Sold by subscription.

It is sometimes hard to find a new thing to say about an admirable book, especially when the space which can be given to a single review is so limited as it is in the REPORTER. It is no small praise to say that the fourth volume of Keating's *Cyclopædia of the Diseases of Children* maintains the high standard of those which preceded it. This volume concludes the work; and the whole Cyclopædia stands a monument of medical, editorial and publishing enterprise and skill, of which American medical men may justly be proud. The present volume contains articles on the ear, the eye, hygiene and diseases of the nervous system. Among them, it would be difficult to select those which are most deserving of commendation; but, in noticing this last volume, we think it is not invidious to call especial attention to the admirable article on physical development by the editor, Dr. Keating, and Dr. J. K. Young.

We call attention to this particular article, because it is a pleasure to add this tribute to the ability which Dr. Keating has displayed in preparing this unusually valuable work.

SPECIAL ARTICLE.

KOCH'S REMEDY FOR TUBERCULOSIS.

A RESUMÉ OF ITS HISTORY.

A glance over the history of the remedy proposed by Koch for the treatment of tuberculosis (in the strict sense of this term) shows that at the Tenth International Medical Congress, last August, he announced that he had discovered a substance which has the power of preventing the growth of tubercle bacilli, not only in the test-tube, but also in the body of an animal. He also said that guinea-pigs, which are extraordinarily susceptible to tuberculosis, "if exposed to the influence of this substance cease to react to the inoculation of tuberculosis virus, and that in guinea-pigs suffering from *general tuberculosis even to a high degree, the morbid process can be brought completely to a standstill.*"

This announcement created intense excitement and great enthusiasm, and aroused the most sanguine hopes that before long Koch would disclose the character of the "substance" which could arrest the progress of tuberculosis in guinea-pigs, and which he evidently expected would do the same in human beings.

After the Congress had adjourned it came to be believed that Koch had given some of the "substance" to certain practitioners and clinicians of Berlin for experimentation upon their patients, and before long the newspapers began to contain statements that patients with consumption were being treated with Koch's remedy, and then that some of them were cured.

Prompted probably by these imperfect reports, Koch, in a special issue of the *Deutsche Medicinishe Wochenschrift*, dated November 13, 1890, made an announcement which was immediately sent by telegraph to newspapers in various parts of the world.

In this communication Koch refrained from disclosing the nature of his proposed remedy, but indicated what he thought its administration would accomplish. To understand what this communication seemed to promise, certain of its expressions must be carefully weighed. After describing the diagnostic value he attributed to it because of its effect upon persons believed to be tuberculous, Koch said: "Very much more important than the significance which the remedy (*Mittel*) has for diagnostic purposes, is its curative action (*Heilwirkung*)." He then described its employment to cure two cases of lupus, and in the treatment of tuberculosis of the glands, bones and joints, and says "the success was the same as in lupus, rapid recovery (*Heilung*) in fresh and light cases, slowly progressing improvement in severe cases." When speaking of the effect of his substance on consumptives, he said: "The action of the remedy expressed itself in consumptives in general in such a manner that the cough and expectoration usually increased somewhat after the first injections, then, however, became less and less, so that in the more favorable cases they finally disappeared entirely." With loosening of the sputum and the disappearance of bacilli in it, until it too ceased, he says that night-sweats ceased, the appearance improved, and the patients gained in weight. As to the ultimate results, he said: "Patients treated in the incipient stage of phthisis were all freed from every symptom of disease in the course of from four to six weeks, so that they could be regarded as cured." He said also: "Patients with not too large cavities were markedly improved and almost cured. According to those experiences I would assume *that incipient phthisis may be cured with certainty* (Sicherheit) *by the remedy.* This may be partially true also of cases which have not progressed too far."

Koch recognized the limitation necessary to his statements on account of the short period during which the cases he thought cured had been under observation, but he said it might well be assumed that possible relapses would be "*as easily and quickly cured as the first attack.*"

The publication of this announcement produced the most extravagant outburst of applause and raised the most boundless expectations that a cure for consumption had been discovered. The daily papers gave the greatest prominence to the doings and sayings of all connected with the experimental application of the substance to which the newspapers gave the name of "lymph,"[1] and patients and medical men flocked to Berlin to get or to have something from Koch and those to whom he entrusted it.

[1] The word "lymph" is no doubt a misnomer, but is used here as a convenient and now recognized term for what Koch called a "remedy" (Heilmittel).

The first full and authentic accounts of what was being done with the "substance" came in the *Deutsche Medicinische Wochenschrift*, of November 20, 1890, which contains reports of the experiences of Fräntzel and Runkwitz, Levy, Köhler and Westphal.

Fräntzel began to use the "lymph" on September 13, and he and Runkwitz give accounts of four cases of far advanced phthisis, none of which were benefited and two of which ended in death before the report was made; of eight cases of moderately advanced phthisis, in which some improvement was noted.

Levy gives an account of the first three cases of surgical tuberculosis treated by Koch's method—the first a case of lupus injected on October 10.

Köhler and Westphal began their treatment on October 11, on eight patients with tubercular disease of the bones and skin, and four patients without tuberculosis. Their account is most full and complete, but they conclude by saying it is only a contribution of facts, and they do not venture to pronounce a judgment in regard to the value of the remedy.

Von Bergmann's communication was the address he delivered before the Free Surgical Association of Berlin, November 16, 1890. In it he gave the results of his experience and mentions the following application of Koch's remedy, exhibiting the patients to the assembly.

LUPUS—13 CASES.

No. of Patients.	No. of Inoc's.	Dates.
1	5	Nov. 6, 8, 10, 12, 14
1		" 6, 7, etc.
1	1	" 6
5	1	" 16, A. M.
5	1	" 16, Ev'g

CERVICAL ADENITIS—3 CASES.

1	5	Nov. 6, 8, 10, 12, 14
1	1	" 16, A. M.
1	1	" 16, Ev'g

JOINT TUBERCULOSIS—16 CASES.

3	5	Nov. 6, 8, 10, 12 14
1	4	" 6, 10, 12, 14
1	1	" 6
4	1	" 16, A. M.
7	1	" 16, Ev'g

TUBERCULAR LARYNGITIS—4 CASES.

1	4	Nov. 10, 12, 14, 16
3	1	" 16, A. M.

He also showed a man who had been supposed to have tubercular laryngitis, but whom he now believed to have carcinoma of the larynx because he did not react, as was expected, to a single injection of Koch's lymph administered that morning.

It will be noted that only nine of these thirty-seven patients had been under treatment as long as ten days; one had been under treatment for only six days; fourteen had had their first injection on the day of the meeting, and thirteen were injected while the meeting was being held. Careful reading of the address shows that Bergmann felt encouraged to hope that the lymph would prove valuable both in the diagnosis and in the treatment of surgical forms of tuberculosis.

The first person to use Koch's fluid in France was Prof. Péan, who, on November 29, described his experiments in a lecture at the Hospital St. Louis, in Paris. He gave a brief account of his observations in fifteen cases and concluded with the statement that "the results do not permit any conclusion in regard to the curative value of the medicament." (*Bulletin Médical*, November 30, 1890.)

Cornil in a lecture at the Laënnec Hospital, November 30, spoke of having administered the "lymph" to a few patients the day before (November 29) and ventured no opinion whatever in regard to its curative power. (*Bulletin Médical*, December 1, 1890.) In a second lecture (*Bulletin Médical*, December 10, 1890) he said that the reaction indicated by Koch had appeared in every case in which he had used the lymph, and this was especially marked in cases in which the tuberculous process was of relatively recent beginning and active. He found the lymph to produce albuminuria and hematuria.

At the Société Medicale des Hôpiteaux, December 5, communications were made by MM. Ferrand, Cuffer and Thibierge, who had just returned from Berlin where they had studied Koch's method under the auspices of the Berlin medical men. Dr. Thibierge had given especial attention to its effect on lupus, and had carefully examined a number of patients who were said in Berlin to be cured. He said to the Society that in view of his own investigations he felt justified in stating that there had not been a single case of even *apparent* cure of lupus with Koch's "lymph." (*Bulletin Médical*, December 7, 1890.)

M. Cuffer described the effect of the "lymph" on cases of lung disease, and called attention to the fact that the remedy depresses the heart and that it is not reliable as an aid to diagnosis because certain cases of tuberculosis have failed to exhibit the promised reaction after its injection.

M. Debove said that his prosector, M. Rémond, stated that he had seen fourteen cases of undoubted tuberculosis in Berlin, in which the reaction had failed to appear. (*Bulletin Médical*, December 7.)

Dr. Charles Talamon, in the *Médecine Moderne*, December 11, 1890, says: "It seems on reading all that has been published so far, as if the only object of pursuit were to obtain the general and local reaction observed by Koch as a consequence of his injection. The more intense this reaction, the more the experimenters seem to be satisfied." He also makes the interesting suggestion that Koch's "lymph" should be used to determine the real nature of bovine tuberculosis—which has been denied to be of the same nature as tuberculosis in mankind—and also to decide what animals are fit for eating and what are dangerous.

Dr. L. Lereboullet, editor of the *Gazette Hebdomadaire*, says in the issue of December 13, that a patient with hip-disease had just died in coma after receiving his second injection by Péan, and that by December 10, eleven cases of death had occurred in Berlin attributable to this treatment.

On November 24, Köhler made an address in the Hygienic Institute of Berlin (*Wiener Med. Presse*, November 30, 1890), going over his experiences for six weeks. He said absolutely nothing new or justifying the belief that the lymph cures anything.

The special correspondent of the *Wiener Med. Presse*, November 30, quotes the disclaimer of Fräntzel and Bergmann that they had obtained actual cures. Fräntzel said he was "only a tyro," Bergmann said: "We must stick to the point that as yet we have not seen a single case of thorough healing." On November 29, Gerhardt said to him, "Here we can only speak of early effects, but not of curative effects." He also calls attention to the unfortunate appearance of greed of gain in cases of many of the medical men who flock to Berlin, and distinctly contrasts what he calls "*Auri sacra fames*" with the old statement: "*Dat Galenus opes.*"

The *Berliner Klinische Wochenschrift*, December 1, 1890, contains a communication by Israel in regard to the anatomical conditions of two cases of joint tuberculosis treated with Koch's remedy. One specimen was taken from the ankle-joint of a patient who had received thirteen injections in the last eight days before the examination was made. The other patient had received seven injections, the last on November 19. One of these cases gave no anatomical evidence of being tuberculous, and the other was very far from conclusive.

The *Münchener Medinische Wochenschrift*, December 2, contains an interesting article by Grünwald, illustrated, showing the effect of the method upon some of the cases of laryngeal tuberculosis treated by Bergmann already referred to. It also contains a summary of the recent publications in regard to Koch's method. Lublinski thinks that the remedy acts favorably upon laryngeal tuberculosis, although he admits that not a single case of real healing has been observed so far, and lays greatest stress upon the value of the lymph as a means of diagnosis.

The *Wiener Medizinische Wochenschrift*, November 30, contains a description of a chemical and microscopical analysis of the fluid of Koch by the Drs. Jolles, by which it appeared that the active principles were certain albuminoids, probably of the group of tox albumin or enzymes.

The *Berliner Klinische Wochenschrift*, December 8, contains an account of the proceedings before the Prussian Legislature in regard to the attitude of the Government towards the preparation and distribution of Koch's material, when Dr. Von Gossler, the minister of public worship (Cultus Minister) announced that the Government would assume control of the matter, and gave, as the chief reason for maintaining secrecy about its composition, the fact that at an interview with him on November 7, "in the presence of two Councillors of State, it was found that Koch was not able (*im Stande*) to give so exact a description of his process as to insure the preparation of an efficient remedy." Something he could tell but, in the opinion of Gossler, not enough to enable even the most skilful bacteriologist to follow his steps exactly and obtain the material he had obtained.

In the *Berliner Klinische Wochenschrift*, December 2, 1890, is a report of a lecture by Krause, on November 27, in regard to his experiences during two weeks and a half with Koch's method. This communication is also of an uncertain sort, expressing more

of hope than of confidence, and confessing that Krause has seen nothing which he could consider a cure.

The *Deutsche Medicinische Wochenschrift*, December 4, contains a communication by Rosenbach, of Breslau, in regard to his observations on fifty-six patients. Again we find the same unsatisfying conclusions founded upon the short period of observation. Rosenbach distinctly states that he is very far from venturing any conclusions in regard to the therapeutic value of this material. A somewhat similiar communication is published from Gerhardt's clinic by Carl von Noorden, in which—as is generally to be noticed in all the German communications—the cases are reported with thorough fidelity, and in sufficient detail to show the careful manner in which the observations have been made, and the candid scientific spirit of those who have made them; but it leads to the same entirely unsatisfactory result, and does not present any good ground for more than hope in regard to its efficiency.

The *Wiener Medizinische Presse*, December 7, 1890, contains an article by Jacksch, of Prague, who believes the remedy to be of a diagnostic value. He thinks that it is a very valuable expectorant in cases of pulmonary tuberculosis. He does not venture to express an opinion in regard to its value in the treatment of lupus.

[TO BE CONTINUED.]

NOTES AND COMMENTS.

Exact Dosage in the Cataphoretic Use of Drugs.

Dr. Frederick Peterson, in the *New York Medical Journal*, November 15, 1890, says that in a previous paper there are figured two cataphoretic electrodes devised for the anodal diffusion of drugs through the skin. The great drawback until the present moment, however, had been the difficulty of accurately regulating the amount of drug introduced. For this purpose rather complicated electrodes had hitherto been required, and even these had been unsatisfactory. He had recently found, however, that all difficulties are easily obviated by the use of a new and exceedingly simple method. Messrs. Waite & Bartlett have made for him a cataphoretic electrode of metal. Instead of covering it, as before, with sponge, the ordinary metal surface is overlaid with a thin disc of platinum, and around the edge of this is placed a narrow rim of soft rubber. The drug to be used is put drop by drop upon a disc of ordinary tissue paper cut to fit the disc of platinum. Filtering paper or linen cloth may be used instead of tissue paper. A disc two or three centimetres in diameter will hold from one to four drops of the solution. When the medicated disc is placed upon the metal surface of the electrode, and the latter then applied to the skin, it is evident that there is a thin capillary layer of the drug in solution exposed to the cataphoretic power of the anode, between the electrode and the skin, and that the quantity of the drug used may be accurately estimated. The current is allowed to flow if desired until the medicated disc becomes perfectly dry. In this way one may introduce, he says, one or more drops of chloroform, methyl chloride, ether, ten-to-twenty-per-cent. solutions of cocaine, a one-per-cent. solution of helleborin, solutions of iodide of potassium, corrosive sublimate, aconitine—in fact, any drug to be employed in this manner.

To further simplify the method, Dr. Peterson has had medicated cataphoretic discs prepared by a pharmacist for use at any time, for the paper discs may be charged with any amount of a watery solution, and, the water being allowed to evaporate, they may be kept on hand indefinitely. It is only necessary to add two or three drops of water to the disc in administering the drug by electricity.

An apothecary has made for him and is prepared to supply any one with the following cataphoretic discs: Discs of menthol, 2 grains; of helleborin $\frac{1}{25}$ grain; of strythnine nitrate, $\frac{1}{32}$ grain; of iodol, 2 grains; of corrosive sublimate, $\frac{1}{8}$ grain; of cocaine hydrochloride, $\frac{2}{5}$ grain; of aconitine, $\frac{1}{64}$ grain; of potassium iodide, 4 grains; of mercury succinimide, $\frac{1}{4}$ grain; of lithium chloride, 4 grains.

Pleasant Laxative for Infants.

According to the *Revue Gènerale de Clin. et de Therapeutique*, March 5, 1890, Ferraud uses as a laxative for infants one or two dessert-spoonfuls of the following mixture in a cup of hot milk or weak tea:

℞ Manna . . . . . ℥vi
Magnesiæ
Sulphur. loti . . . . . aa ℥iss
Mellis . . . . . f℥vi

Evidences of Criminal Poisoning.

In a paper read before the Medical Jurisprudence Society, of Philadelphia, November 11, 1890, Professor John J. Reese, M. D., read an interesting paper on the subject of "What Constitutes Reliable Evidence in Criminal Poisoning." The evidences he grouped under the heads of those derived from the symptoms before death; those derived from *post-mortem* appearances, especially as regarded the stomach; those obtained from chemical analysis; the evidences obtained by experimenting on living animals; and those derived from the circumstances of the case.

In reference to the evidences derived from the symptoms before death, he said it would be impossible to diagnosticate a case on such symptoms exclusively, as certain diseases presented similar symptoms. An exception might be made in poisoning with strong mineral acids, or with hydrocyanic acid. On the other hand, he had known cases of arsenical poisoning to be mistaken for cholera morbus. The second class of evidences, while strongly suggestive, like the first, could not, he said, be regarded as absolute proof, on account of the resemblance to pathological conditions found in certain diseases. It would not be safe, Dr. Reese said, to found a positive diagnosis on the pathological appearance of the lining of the stomach, as many cases of arsenical poisoning had occurred without leaving any evidence of its action on the lining of that organ.

In reference to evidences derived from chemical analysis, he said there were a number of poisons which could not be recognized by any known chemical tests, and other measures had, therefore, to be resorted to. The presence of a poison in the stomach or other organs did not necessarily mean that death was caused by the poison, as the latter might have been injected after death.

Where there was a failure to detect poisons by chemical analysis, it was necessary sometimes to resort to experiments upon living animals, such as dogs, cats and guinea-pigs. But often the most important evidences were those derived from the circumstances of the case, and, in the majority of cases, the evidence was mainly, if not exclusively, circumstantial. Rarely does it happen that there is direct proof of the administration of the poison.

In conclusion, Dr. Reese spoke of the various circumstances to be considered in a given case; such as the proven purchase and possession of the poison by an accused person; the exercise of an exclusive care of the victim during his illness by the accused; and the existence of a sufficient motive on the part of the accused.

Treatment of Delirium Tremens.

At the Congress of German Naturalists, September 15–19, 1890, Aufrecht, of Magdeburg, made some remarks upon the treatment of delirium tremens, which are reported in *Le Mercredi Medical*, November 5, 1890. Two questions, he said, present themselves: Can the disease be radically cured? Is it useful to continue to give alcohol to patients with delirium tremens?

Aufrecht has treated two hundred and ninety-four alcoholic patients between the years 1880 and 1890, and of this number has lost ten. He treated twenty-two patients with chloral and morphine, and four died; since then he has used chloral alone without any failure. He gives chloral in doses of sixty grains, according to the following formula:

℞ Chloralis . . . . . ʒi
Syrupi
Tinct. Aurantii Am. Cort. . . . aa fʒss
M.

This potion, he says, is well borne by patients. It takes effect the first night, but it should be repeated the next night and the night following, so that repose may be complete. At times, in serious cases, thirty grains of chloral should be prescribed in the morning and the same dose (60 grains?) continued every evening for four or five days.

When one has to deal with all sorts of patients who at the same time are alcoholic, it is necessary to treat them actively. Aufrecht gives six fluid ounces a day of Hungarian wine, or the following potion:

℞ Alcoholis (90 per cent.) . . . . . fʒii
Syrupi . . . . . ɱclx
Tinct. Aromat.
Tinct. Amar . . . . . aa ɱxv
Aq. Amygdale. Amar. . . . . ɱiii
Aq. destill. . . . . fʒviss
Sacchari . . . . . qs.
M.

At times, he says, this treatment does not

stop the delirium. He then prescribes forty-five grains of chloral, and has obtained very good effects from it. He says that patients with alcoholic delirium, who have no other affection, do not need alcohol.

Reduction of Hip Dislocations.

Mr. H. Herbert, Surgeon I. M. S., Acting Civil Surgeon at Aden, writes to the *British Medical Journal*, November 8, 1890: An adult Arab was admitted with an old dorsal dislocation of right hip. He had fallen from a camel quite a month before on the outer side of the limb. Thus the displacement was probably direct, and produced by forcible adduction. Hence, possibly, the failure to reduce it by the orthodox manipulations, based on the assumption of all cases being conversions of primary thyroid dislocations. Manipulations and pulleys were alternately tried for quite an hour under chloroform; but the pulleys were practically of no use, owing to the thigh band being too large. At the end of this time the limb could be abducted freely, though scarcely at all at first; and when the limb was pulled vertically upwards there was considerable movement of the head of the bone grating on the ileum. Still we quite failed with the regular movements; so, while an assistant, seizing the limb below the bent knee, pulled forcibly upwards, with the thigh fully abducted and flexed at rather more than a right angle, I, kneeling on the sound side of the patient, wrapped my arms round the limb near the hip, and, leaning my weight on the inside of the knee, so levered the head of the bone up into the acetabulum. The reduction has been permanent. The great ease with which the bone went in suggests that this method may be of somewhat general application. In old cases it probably needs free preliminary movements to break up adhesions. The extension may, of course, be made with pulleys. The essential thing is the maintenance of full abduction, while the head of the bone is pressed up into position.

Bonducine as a Febrifuge.

Bonduc is said by the *Journal de Médecine*, Oct. 12, 1890, to be the fruit of *Guilandila Bonducella* and of the *Cæsalpinia Bonduc*. The oily cotyledons contain a bitter, resinous principle, which is extracted by alcohol. The alcoholic extract is treated with chloroform, water is added to the chloroform solution, and, after agitation, the inferior layer, which contains the bitter principle, is evaporated and washed with ether and petroleum. A white powder is thus obtained, which is bitter, not acrid, soluble in alcohol, chloroform, acetone, acetic acid, fixed and volatile oils; it is sparingly soluble in ether and sulphide of carbon, and nearly insoluble in water, ether and petroleum.

This bitter principle, called bonducine, is soluble in hydrochloric acid, which it colors rose; with sulphuric acid the acid is an amaranth red, made more perceptible on the addition of a drop of chloride of iron. It is administered with success in intermittent fevers, in the dose of one and two-thirds to two and one-third grains. The powder is given in doses of fifteen or thirty grains a day.

The Quantity of Blood in the Brain.

Professor Roy and C. S. Sherrington (*Journal of Physiology*, vol. xi, p. 85), have examined the influence on the cerebral circulation of stimulation of sensory nerves, of the sympathetic, of voluntary movements, and of the action of drugs. The quantity of blood received by the brain is in proportion to the general blood pressure. They state, also, that the chemical products of cerebral metabolism contained in the lymph which bathes the walls of the arterioles of the brain, can produce variations in the caliber of the cerebral vessels, whence it follows that the brain possesses an intrinsic mechanism by whose aid the quantity of blood is made to vary locally in relation to the local variations of functional activity.—*Glasgow Medical Journal*, October, 1890.

Hydrazoic Acid.

Professor Curtius has recently discovered a body which is gaseous, and which has the formula HN_3. It is made by the interaction of two molecules of hydrazine (N_2H_4) with one of benzoylglycollate. Benzoyl-hydrazine is one of the products, and this on heating with nitric acid is changed to the nitroso compound, which on dehydration is changed to benzoylazoimide, and saponification does the rest.—*Chemist and Druggist*, November 1, 1890.

New Remedies and New Combinations.

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A CASE WITH A LESSON IN IT.

We have frequently referred to the necessity of keeping the pregnant woman supplied with those chemical substances which she must give to the child in the formation of its little frame, and the dire effects which may result from a deficiency of those substances. The headaches, neuralgias, spinal tenderness, and some of the many disorders of digestion, and even mental failure, may be all prevented or relieved by supplying to the mother the chemical food her system demands.

We have noticed a few cases where the most serious results have occurred to the mother by such a deficiency, one of which is well worth relating. Mrs. M., aged 30, pregnant with her third child, suffered from the second to the fifth month of her pregnant term with gradually failing strength and health, and nervous irritability. She was very restless nights for three or four days, the peculiar restlessness of complete nervous exhaustion, and was irrational for more than a week.

At this time I advised that she have a teaspoonful of Murdock's Liquid Food every hour in milk, and a little wine every four hours. The third night she had fifteen drops of hydrobromic acid dil. every three or four hours, which was continued for a week. The liquid food after a week every two hours, and all other medicines were discontinued. Her bowels were moved with a mild laxative at first, and afterward became regular. Her tongue cleaned quickly and her skin assumed a more natural appearance.

At this writing, less than three weeks from our first visit, the patient is able to sit up an hour at a time, is quite rational and cheerful, has a good appetite, the bowels are quite regular, there is no headache, and but little spinal tenderness. She sleeps reasonably well if fed frequently. She is allowed to suit her taste in her diet. The child is quite active, and the mother is progressing so nicely that it is hoped that she will pass safely through her confinement, which is nearly at hand. She will be kept on the liquid food and the phosphates until her confinement after which, the condition will suggest the treatment. This is the most marked case of a starved nervous system we have ever seen, and the benefit derived from the treatment proves the theory as to the cause of the trouble.

Apropos with the above, comes the question of the selection of nutritious foods for those many cases which demand strong and immediate nourishment. The food used in the above case has produced marvelous results for us in some of those extreme cases in which we have used it.

In one case of nervous exhaustion the insomnia was absolutely painful. When the exhaustion forced the patient to sleep there was an immediate sense of falling or approaching death, or there were hallucinations which were appalling, rendering the nights unbearable. One teaspoonful of Murdock's Liquid Food so nourished the system the first night it was given that the patient sank into a quiet, refreshing sleep which lasted, with a single awakening, until morning, and the improvement the patient obtained was most striking.

One case of mitral regurgitation with leucocythemia and nervous exhaustion improved more rapidly on this food than on all other measures combined. In cases of nervous exhaustion and brain tire, its effects are most marked, as we have experienced many times in the past five years in the frequent personal use of the agent. It contains the principles of pure, healthy blood and nerve tissue ready for immediate assimilation. Fourteen per cent. of the entire quantity is uncoagulated albumen, as we have demonstrated by actual analysis.

We have tided babies over critical periods often with a few drops in its usual diet. We have given it to dipsomaniacs with or without non-alcoholic stimulants with superb results. The sole objection our patients have to it is its odor. Its taste is not disagreeable; it has the odor and appearance of blood. All objections are soon forgotten, however, in the results of its action upon the nutrition of the system, and the patient soon learns to like it, and often craves for it, drinking it from the bottle or a glass readily, like any beverage. It ought to be the food par-excellence for rapid appropriation in all conditions of exhaustion.

P. S.—Phosphates act well with the Liquid Food.

Editorial of the Chicago *Medical Times*, June, 1890.

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CONTENTS:

SIR MORELL MACKENZIE, in the *Journal of Laryngology*, published in London, says the following:

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"I am, Sir, yours faithfully,

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